

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Please return the certificate to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the time of death, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items, 2a., & 22a., G-579, 5/27/83
Gb.j. / also 2b.,

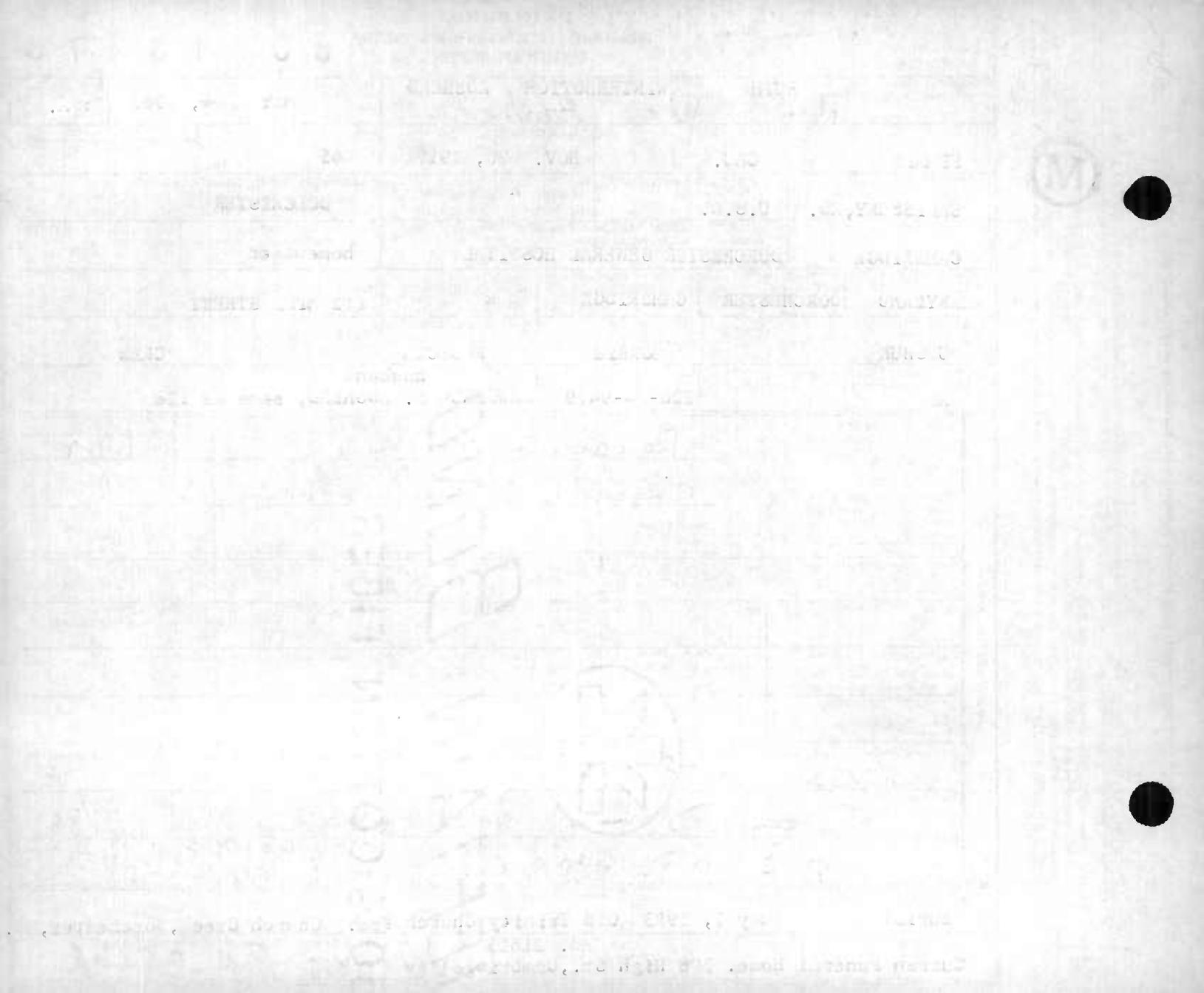
FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3
REG. NO.

1 3 4 1 3

DECEASED NAME (TYPE OR PRINT)	FIRST RUTH Ruth	MIDDLE WINTERBOTTOM W - Adshead	ADSHEAD	2a. DATE OF DEATH MAY 5, 1983	MONTH MAY	DAY 5	YEAR 1983	2b. HOUR 5:05 A.M.
3. SEX FEMALE	4. RACE CAU.	5. DATE OF BIRTH MONTH NOV. DAY 20, 1917 YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE COUNTRY SALISBURY, MD.	7b. CITIZEN OF WHAT COUNTRY U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER				MD.	
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND	13b. COUNTY DORCHESTER	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 112 MILL STREET		21613		
14. FATHER'S NAME FIRST UPSHUR	MIDDLE	LAST MORRIS	15. MOTHER'S MAIDEN NAME FIRST REBECCA	MIDDLE	LAST CREW			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO	16c. SOCIAL SECURITY NO. 220-34-9479	17. INFORMANT husband LAWRENCE E. ADSHEAD, same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11/14 YRS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). { DUE TO, OR AS A CONSEQUENCE OF b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. COR PULMONALE								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/5/83</u> to <u>5/5/83</u> , that (I) (we) last saw the deceased alive on <u>5/5/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did not view the body after death, <input type="checkbox"/>								
22b. SIGNATURE Curran Funeral Home								
22c. DEGREE NO ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. A. D. Curran Funeral Home.								
22e. ADDRESS 501 High St., Cambridge, MD 21613								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE May 7, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Old Trinity Church Cem.	23d. LOCATION CITY OR TOWN Church Creek, Dorchester, Md.	23e. COUNTY	23f. STATE			
24. FUNERAL DIRECTOR NAME Curran Funeral Home.	ADDRESS 308 High St., Cambridge	Md. 21613	25a. DATE REC'D. BY REGISTRAR MAY 10 1983	25b. REGISTRAR'S SIGNATURE John J. Curran				

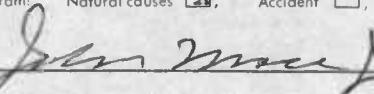


(3)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 3 AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT FOR 24 HOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 3 4 1 4

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
Mildred			M.	Anderson		<input checked="" type="checkbox"/>	5	6	1983	AM
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR
Female	Negro	7 3 1927	55 yrs.	MONTHS	DAYS	HOURS	MIN.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Md.		USA								Dorchester County MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		DOA Dorchester General Hospital			Housewife					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 514 Pine St. 21613				
Md.		Dor.		Cambridge						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
William		B.	Cooper	Mable		Brittingham				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		218-20-2590		Raymond Cooper		Cambridge, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DOUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DOUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20d. AUTOPSY?					
					<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE  EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.								TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial								DATE 5-12-83	23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery	23d. LOCATION CITY OR TOWN Cambridge, Dor., Md.
24. FUNERAL DIRECTOR NAME St. Clair Funerals								ADDRESS Cambridge, Md.	25a. DATE REC'D. BY REGISTRAR MAY 9 1983	25b. REGISTRAR'S SIGNATURE 
BP		DHMH-17 (VR A15 ME (5)) 15M7/77								

RECEIVED

RECEIVED

RECEIVED

RECEIVED - APPROVED FOR RELEASE

RECEIVED

RECEIVED

RECEIVED

RECEIVED - APPROVED FOR RELEASE

RECEIVED - APPROVED FOR RELEASE

RECEIVED

RECEIVED

RECEIVED - APPROVED FOR RELEASE

RECEIVED - APPROVED FOR RELEASE - APPROVED FOR RELEASE

RECEIVED - APPROVED FOR RELEASE - APPROVED FOR RELEASE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3

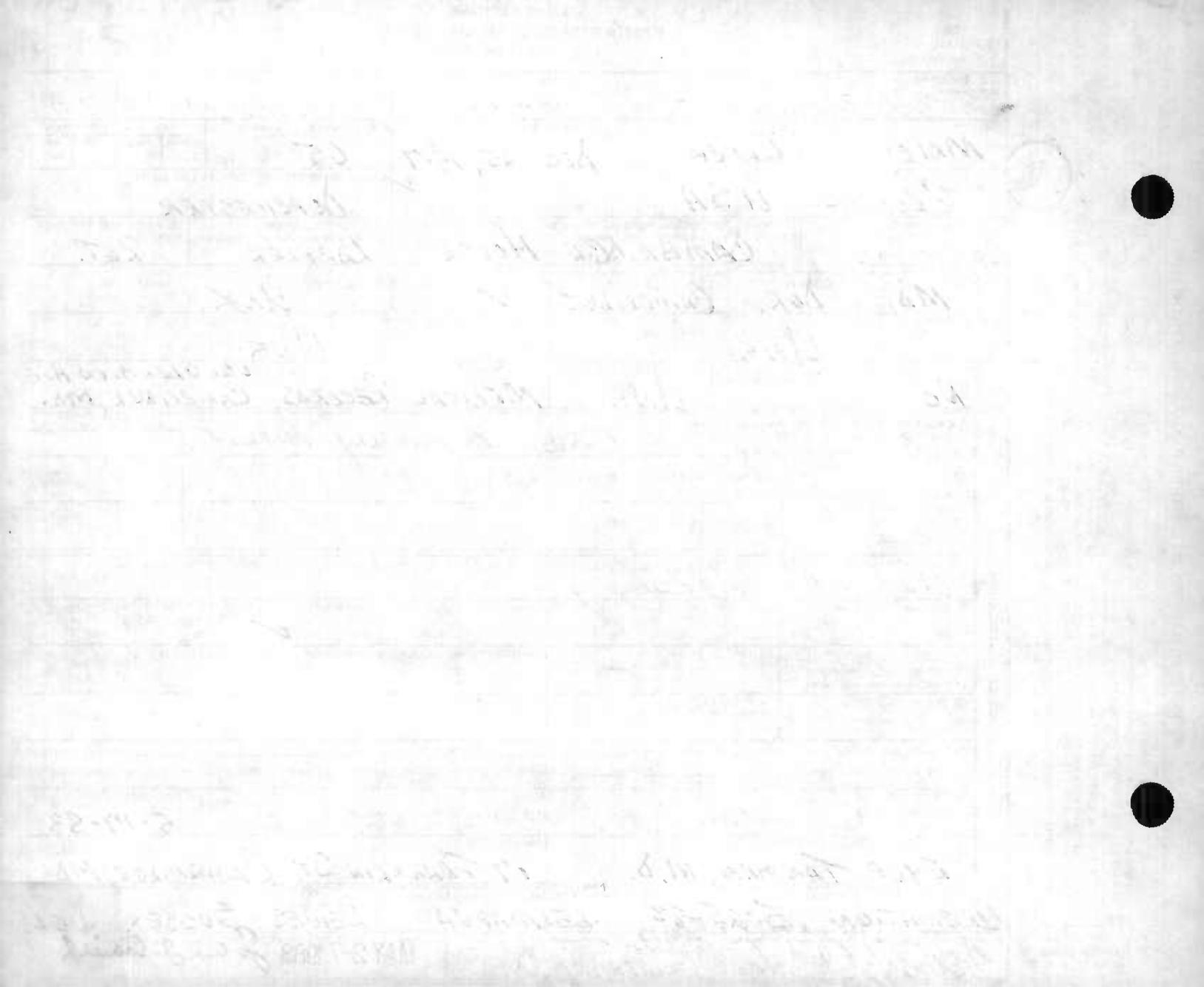
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3	1 3 4 1 5			
1 - STATE REGISTRAR											REG. NO.					
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
BOOKER T.			ASHLEY						MAY 17, 1983			7 A M				
3. SEX MALE			4 RACE Black			5. DATE OF BIRTH DEC 25, 1917			6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE COUNTRY GEORGIA			7b. CITIZEN OF WHAT COUNTRY? USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7c. BALTIMORE CITY OR COUNTY OF DEATH ROCHESTER			MD.				
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) CAMBRIDGE HOUSE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY REI							
13a. STATE Md.			13b. COUNTY DOR.			13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS UNK. 21613				
14. FATHER'S NAME FIRST MIDDLE LAST UNK.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO UNK.			17. INFORMANT ADDRESS Medical Records CAMBRIDGE, MD.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardio - Respiratory Arrest</i>			DUE TO, OR AS A CONSEQUENCE OF (c) <i>AS CVD</i>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Old CVA c (2) Hemiplegia																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Cauffman</i>			22c. DEGREE M.D.			22d. ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 5-17-83							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) EYUP TANMAN, M.D.			22g. ADDRESS 17 FRANKLIN ST. CAMBRIDGE, MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 5-25-83			23c. NAME OF CEMETERY OR CREMATORIAL SERVANIA			23d. LOCATION CITY OR TOWN LEWES COUNTY SUSSEX STATE DEL							
24. FUNERAL DIRECTOR NAME Frederick			25a. PLACE ADDRESS CLAY T. HOME CAMBRIDGE, MD.			25b. DATE REC'D. BY REGISTRAR MAY 27 1983			25c. REGISTRAR'S SIGNATURE John G. Cauffman							

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79



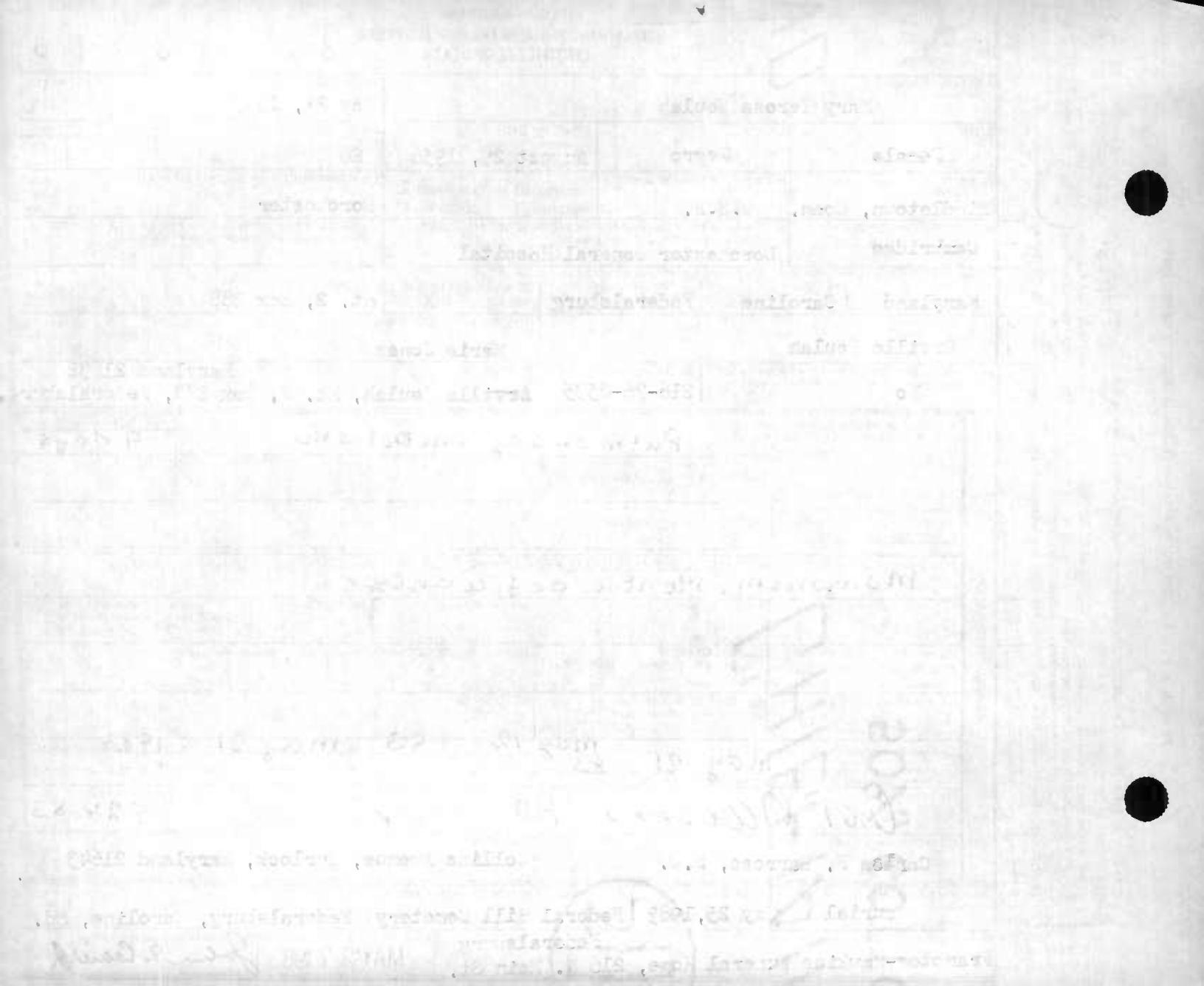
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				3. HOUR					
Mary Teresa Beulah				May 21, 1983				M					
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7. BIRTHPLACE COUNTRY Middletown, Conn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester		10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 288	
14. FATHER'S NAME FIRST Orville Beulah		15. MOTHER'S MAIDEN NAME FIRST Marie Jones		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-76-8535		17. INFORMANT Arville Beulah, Rt. 2, Box 288, Federalsburg		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4151		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 12</u> , 19 <u>83</u> , to <u>May 21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Orville Beulah, M.D.		22c. DEGREE DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 5.24 83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Barroso, M.D.		22e. ADDRESS Collins Avenue, Hurlock, Maryland 21643											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 25, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Federal Hill Cemetery		23d. LOCATION CITY OR TOWN Federalsburg, Caroline, Md.							
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.		ADDRESS Federalsburg		25a. DATE REC'D. BY REGISTRAR MAY 27 1983		25b. REGISTRAR'S SIGNATURE John J. Coniglio							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH CERTIFICATE IS ISSUED WITHIN 24 HOURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 4 1 7

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED		XX MONTH DAY YEAR	2b. HOUR	
Lawrence			W. (Wilbur) Clifford, Jr.			<input checked="" type="checkbox"/>		5 4 19 83	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d. HOUR	
Male	White	Aug. 2 1928	54 yrs.			<input type="checkbox"/>		5 4 19 83	9:50 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		USA			<input type="checkbox"/>		Dorchester County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Dorchester County General Hosp, Hydro-graphic Tech.					U.S. Army			
13. STATE		14. COUNTY	15. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Md.		Queen Ann's	Stevensville	<input type="checkbox"/>		P.O. Box 316, 21666				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		LAST				
Lawrence		W.	Clifford	Anna		Sapp				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
Yes		212-26-5695			Ann C. Clifford, P.O. Box 316, 21666					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/>		and in my opinion						
ACTUAL SIGNATURE		M.C. <i>Chomed J. Smith</i>		TITLE (SPECIFY) Deputy Chief		MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.			ADDRESS		DATE SIGNED			5/10/83
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		5/7/83	Parkwood Cemetery			Parkville		Balto.	Md.	
24. FUNERAL DIRECTOR		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR SIGNATURE			
J. E. Lowell Lemmon		10 W. Padonia Rd.			MAY 11 1983		<i>John G. Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 states any injury, or other traumatic event, the medical examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8313418 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
KENNETH NMI COMBES						5 23 83						9:40 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
M		Cau		MONTH 9 DAY 22 YEAR 21			61			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
NEW YORK		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			DORCHESTER								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CAMBRIDGE		DORCHESTER GENERAL HOSPITAL										construction		AIRCRAFT	
13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN WOOLFORD			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS R.D. 1, Box 76		21677			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
JOSEPH COMBES		LUCILLE SCHMITT													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
YES WW II		069-14-2958		WIFE			MRS. HELEN COMBES, same as 13e								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CARDIAC FAILURE															
DUE TO, OR AS A CONSEQUENCE OF (b) ASHD															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (i) (this hospital) attended the deceased from 5-23-83 to 5-23-83, that (i) (we) last saw the deceased alive on 5-23-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.															
22b. SIGNATURE R. NORTON HALL, M.D.		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 5/23/83							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN LEWES		CITY OR TOWN LEWES		COUNTY DELAWARE				
cremation		May 23, 1983		DELMARVA CREMATORIAL											
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME, 308 High St., Cambridge		ADDRESS Maryland 21613			25a. DATE REC'D. BY REGISTRAR MAY 24 1983		25b. REGISTRAR'S SIGNATURE John J. Curran								

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be sent with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 REG. NO. 1 3 4 1 9							
1 - STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST JOHN CHARLES DODD			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH 4 DAY 4 YEAR 01			6. AGE (IN YEARS LAST BIRTHDAY) 79 82 YRS.			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN			IF UNDER 24 HRS MONTHS 0 DAYS 0 HOURS 0 MIN		
7a. BIRTHPLACE (STATE OR FOREIGN Talbot County Md.)			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			10. CITY OR TOWN OF DEATH Maryland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION East St. Hosp. CENTER		
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.			13a. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Federal Street			12a. USUAL OCCUPATION PAINTER		
14. FATHER'S NAME FIRST James MIDDLE Dodd LAST			15. MOTHER'S M AIDEN NAME Fannie			16. SOCIAL SECURITY NO. 212-30-6616			17. INFORMANT Marjorie Dodd, Easton, Md.			18. KIND OF BUSINESS OR INDUSTRY 21601					
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			18b. IMMEDIATE CAUSE (a) 4850			18c. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any (b)			18d. DUE TO, OR AS A CONSEQUENCE OF (c)			18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18f. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> , 19 <u>73</u> , to <u>5/5</u> , 19 <u>73</u> , that (I) (we) last saw the deceased alive on <u>5/4</u> , 19 <u>73</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Edo H. Beck MD			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 5/5/83								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Edo H. Beck MD			22f. ADDRESS E. S. H. C. CAMBRIDGE MD 21443														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE May 5, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewis, Sussex, Del.			COUNTY			STATE		
24. FUNERAL DIRECTOR NAME H. Torbert Williamson			25a. DATE REC'D. BY REGISTRAR MAY 12 1983			25b. REGISTRAR'S SIGNATURE John J. Connel											

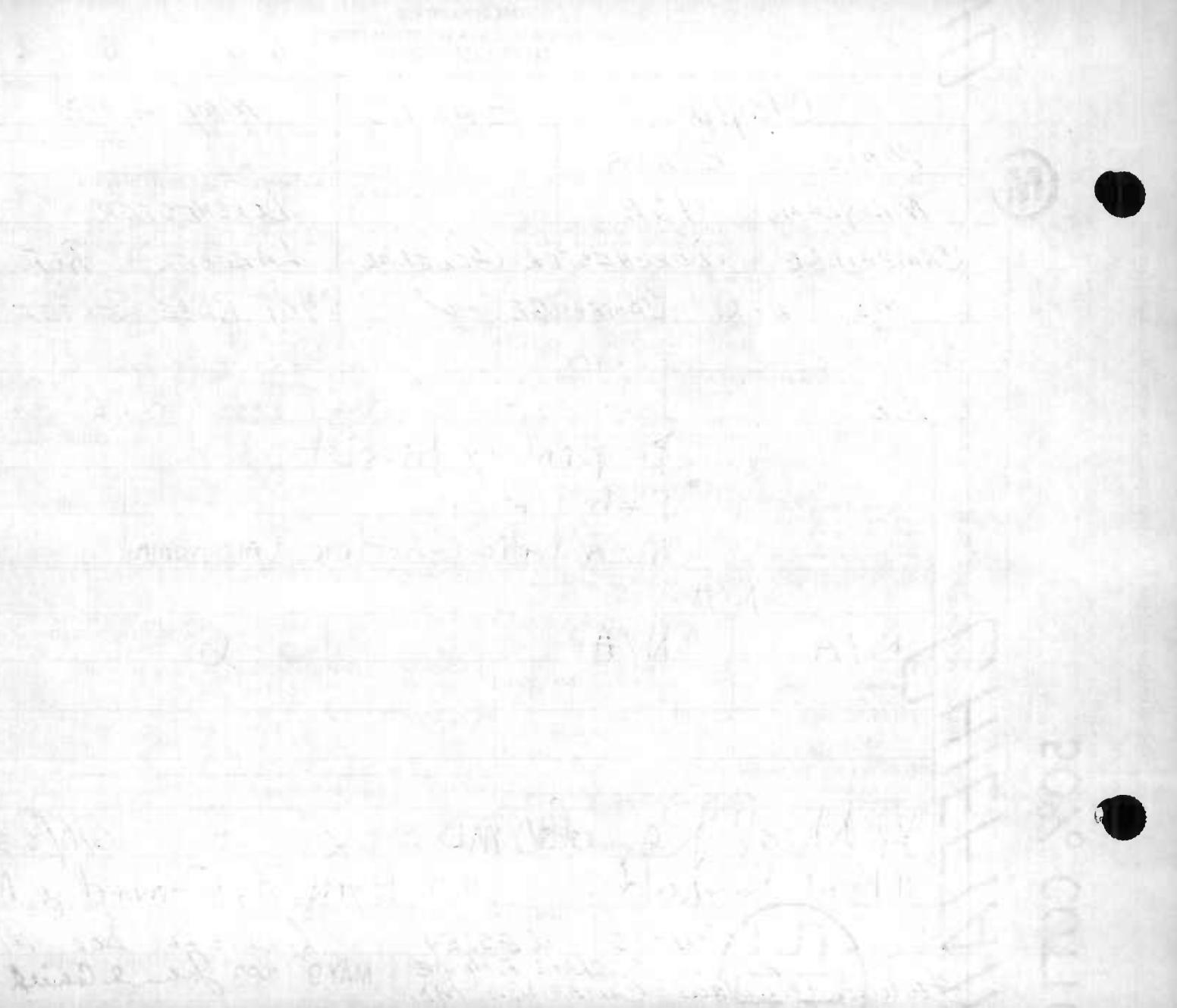
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to a burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

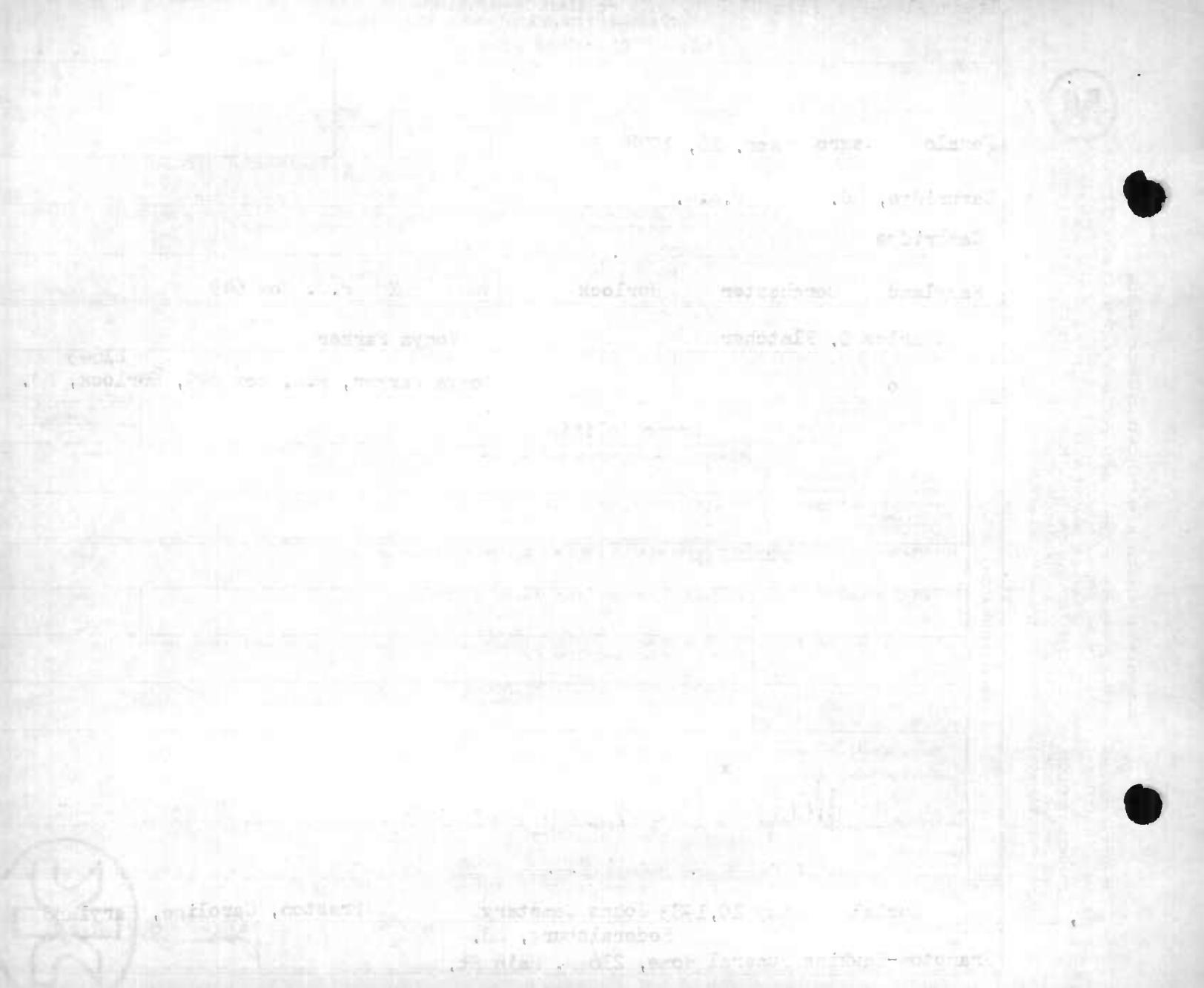
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 1 3 4 2 0 REG. NO.
1. FOR STATE REGISTRAR			Clayton			Ferrals			MAY 6, 1983			2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
3. SEX MALE			RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR Sept 18 1916			6. AGE (IN YEARS LAST BIRTHDAY) 66			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE COUNTRY MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER			MD.
10. CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL			12a. USUAL OCCUPATION LABORER			12b. KIND OF BUSINESS OR INDUSTRY REI.			
13a. STATE MD.			13b. COUNTY DOR.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 701 RACE STREET			
14. FATHER'S NAME FIRST MIDDLE LAST Frederick			15. MOTHER'S MAIDEN NAME Unknown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 222-02-9479			17. INFORMANT Irene Ferrals 804 Mac's Lane Md. 20943
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) DOUE TO, OR AS A CONSEQUENCE OF (b) Dehydration												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.)												
22b. SIGNATURE H. Neal Reynolds MD			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 5/6/83						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) H. Neal Reynolds			22f. ADDRESS 408 Byn St, Cambridge Md									
23a. BURIAL, CREMATION, REMOVAL Ferial			23b. DATE 5-11-83			23c. NAME OF CEMETERY OR CREMATORIAL WESLEY			23d. LOCATION CITY OR TOWN Lincroft Rd. Ao 178, COUNTY SUSSEX			
24. FUNERAL DIRECTOR Name Frederick C. Atkin			24. ADDRESS ST CLAIR F. HOME CAMBRIDGE, MD.			25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE MAY 9 1983 John & Carol						



ITEMS #10a-22a Film G582 8/3/83 rc STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3 REG. NO. 3 4 2 1											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST		
LISA						FLETCHER					
2a. DATE KNOWN OF ESTI. DEATH MATED		<input checked="" type="checkbox"/>		MONTH		DAY		YEAR		2b. HOUR	
5-6-83				19						19	
2c. DATE PRONOUNCED DEAD				MONTH		DAY		YEAR		2d. HOUR	
5-6-83				19						7:58P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED		NEVER MARRIED		<input checked="" type="checkbox"/>	
Cambridge, Md.		U.S.A.		5		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH		Dorchester County MD.									
10. ID CITY OR TOWN OF DEATH		Cambridge									
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Dorchester Co Hospital									
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		Dorchester		Hurlock		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 649		21643	
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			
Charles D. Fletcher								Vonya Parker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) If YES, GIVE WAR OR DATES		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				21643	
No						Vonya Parker, P.O. Box 649, Hurlock, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 4661 Bronchiolitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Margraita A. Korell, M.D.		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		5-7-83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		May 10, 1983		Johns Cemetery		Preston		Caroline		Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		Federalsburg, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Frampton-Hawkins Funeral Home, 216 N. Main St.						MAY 11 1983		John G. Smith			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR RECORDS. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS. DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMH - 17
(VR A15 ME (5))
20M 4/B2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 3 REG. NO. 1 3 4 2 2												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Ruth Delores Gillis						May 7 1983			9:30pm			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
female		white		10 27 1916			66 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester		
N. Carolina		U. S. A.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge		Dorchester General Hospital		teacher-public schools								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE Md.		13c. COUNTY Dorchester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Steamboat Lane 21677				
				13e. CITY OR TOWN Woolford								
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
		William R. Gillis		Annie			213-16-7914			Marvin W. Gillis Arlington Va.		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. IF YES, GIVE WAR OR DATES		18c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18d. DUE TO, OR AS A CONSEQUENCE OF (b) Cholecystectomy May 5, 1983			18e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours		
yes		WW 2		5751								
19a. DATE OF OPERATION 5/5/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 83</u> to <u>May 7 1983</u> , that (I) (we) lost saw the deceased alive on <u>May 7 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Lewis M. Burdette MD				DEGREE						22c. DATE SIGNED 5/9/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burdette				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 4 Aurora St					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5/10/1983		23c. NAME OF CEMETERY OR CREMATORIAL Md. Veterans Cem.			23d. LOCATION CITY OR TOWN Beulah Dor.			COUNTY		STATE
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD 21613		25a. DATE REC'D. BY REGISTRAR MAY 16 1983			25b. REGISTRAR'S SIGNATURE John J. Conner					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

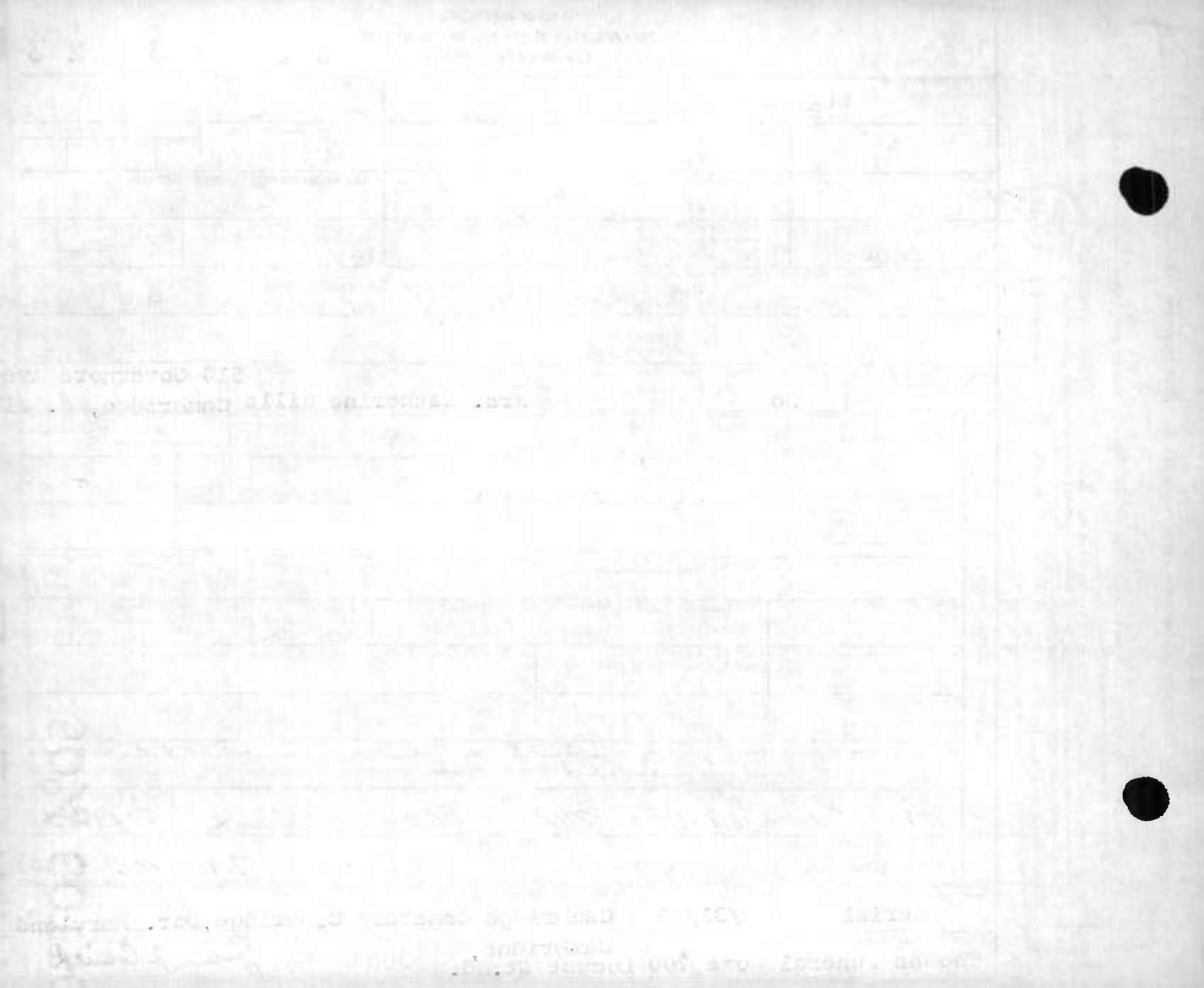
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the medical examiner's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at this time.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH83
REG. NO.

13423

1. DECEASED NAME (TYPE OR PRINT)			FIRST HENRY	MIDDLE -	LAST GORE	2a. DATE OF DEATH 05-28-83	MONTH JUN	DAY 6	YEAR 1983	2b. HOUR 1 P M			
3. SEX M		4. RACE CAU		5. DATE OF BIRTH MONTH 05		DAY 10	YEAR 90	6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.							
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GEN. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.		12b. KIND OF BUSINESS OR INDUSTRY							
13. STATE MD.		13b. COUNTY DORCHESTER	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 520 GLEN BURN AVE. CAMBRIDGE		21613					
14. FATHER'S NAME JOHN		MIDDLE -	LAST GORE	15. MOTHER'S MAIDEN NAME ELIZ.		LAST HUGHES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-05-6276		17. INFORMANT Mrs. Catherine Mills Cambridge, Md.		ADDRESS 510 Governors Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DOUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DOUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH — days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> , 19 <u>83</u> , to <u>5-28</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5/28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 5/28/83	
22b. SIGNATURE <u>Henry W. Sundermier MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Henry W. Sundermier</u>		22e. ADDRESS 22 S. GREEN ST. BART MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/31/83		23c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery		23d. LOCATION CITY OR TOWN Cambridge		COUNTY Dor.		STATE Maryland			
24. FUNERAL DIRECTOR NAME Thomas Funeral Home		ADDRESS 700 Locust St. Md.		25a. DATE REC'D. BY REGISTRAR JUN 6 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Coughlin</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 3 1 3 4 2 4 REC. NO.											
1. FOR STATE REGISTRAR			I. DECEASED NAME FIRST Harper Tina E			MIDDLE Harper			LAST		
3. SEX Fe			4. RACE Cauc			5. DATE OF BIRTH MONTH 6 DAY 10 YEAR 05			2a. DATE OF DEATH May 20 1983		
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE MD			13b. COUNTY Dorchester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rural 21823		
14. FATHER'S NAME Riley			13c. CITY OR TOWN Elliott			15. MOTHER'S MAIDEN NAME Lovey			LAST Gray		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 222-03-0163			17. INFORMANT Box 268A Phyllis Wroten Preston, MD 21655					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Refractory Hypotension</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Persistent Hypoxia 20% Pulm failure</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Neal Reynolds			DEGREE ATTENDING PHYSICIAN			22c. MEDICAL DIRECTOR			22d. STAFF PHYSICIAN		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) H. Neal Reynolds			22f. ADDRESS 408 Bynn Street Cambridge			22g. DATE SIGNED 5/24/83					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-23-83			23c. NAME OF CEMETERY OR CREMATORIAL Brookview Cemetery			23d. LOCATION CITY OR TOWN Brookview, Dorchester, MD COUNTY STATE		
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD						25a. DATE REC'D. BY REGISTRAR JUN 1 3 1983			25b. REGISTRAR'S SIGNATURE Jacqueline C. Clegg		

10 of 10

TO MEDICAL DIRECTOR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS EXECUTE THE EXAMINER, WRITING THE WORD "RE-DOING" IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 4 FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS (44-21201) AFTER DEATH, WITHIN 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 4 2 5	
1- STATE REGISTRAR		1. DECEASED NAME / (TYPE OR PRINT)						MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED	
		Paul Roger Hart										<input checked="" type="checkbox"/> MONTH DAY YEAR 5-10 1983 AM	
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2b. HOUR	
Male		White		MONTH DAY YEAR		8 15 41		MONTHS DAYS		HOURS MIN.		2b. HOUR	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA										Dorchester County	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge		Dorchester General						Repair-Auto Body&Fender					
13. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD		Dorchester		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		408 Maryland Ave. 21631					
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME							
William		Melvin		Hart		Hilda							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)						17. INFORMANT		ADDRESS			
No		212-40-8705						Patricia A. Hart		409 Locust St. Cambridge, MD			
III. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>												<u>Few Mins</u>	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED <u>5-12-83</u>	
ACTUAL SIGNATURE <u>John Mace Jr.</u>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER											
EXAMINER'S NAME / (TYPE OR PRINT)		ADDRESS										Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		5-12-83		Sandy Island		Robbins, Dorchester,		Md.					
24. FUNERAL DIRECTOR		ADDRESS										25a. DATE REC'D. BY REGISTRAR	
Zeller Funeral Home, East New Market, Md.												MAY 25 1983	
25b. REGISTRAR'S SIGNATURE <u>John G. Conner</u>													
BP		DHM-17 (VR A15 M55) 15M 7/77											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

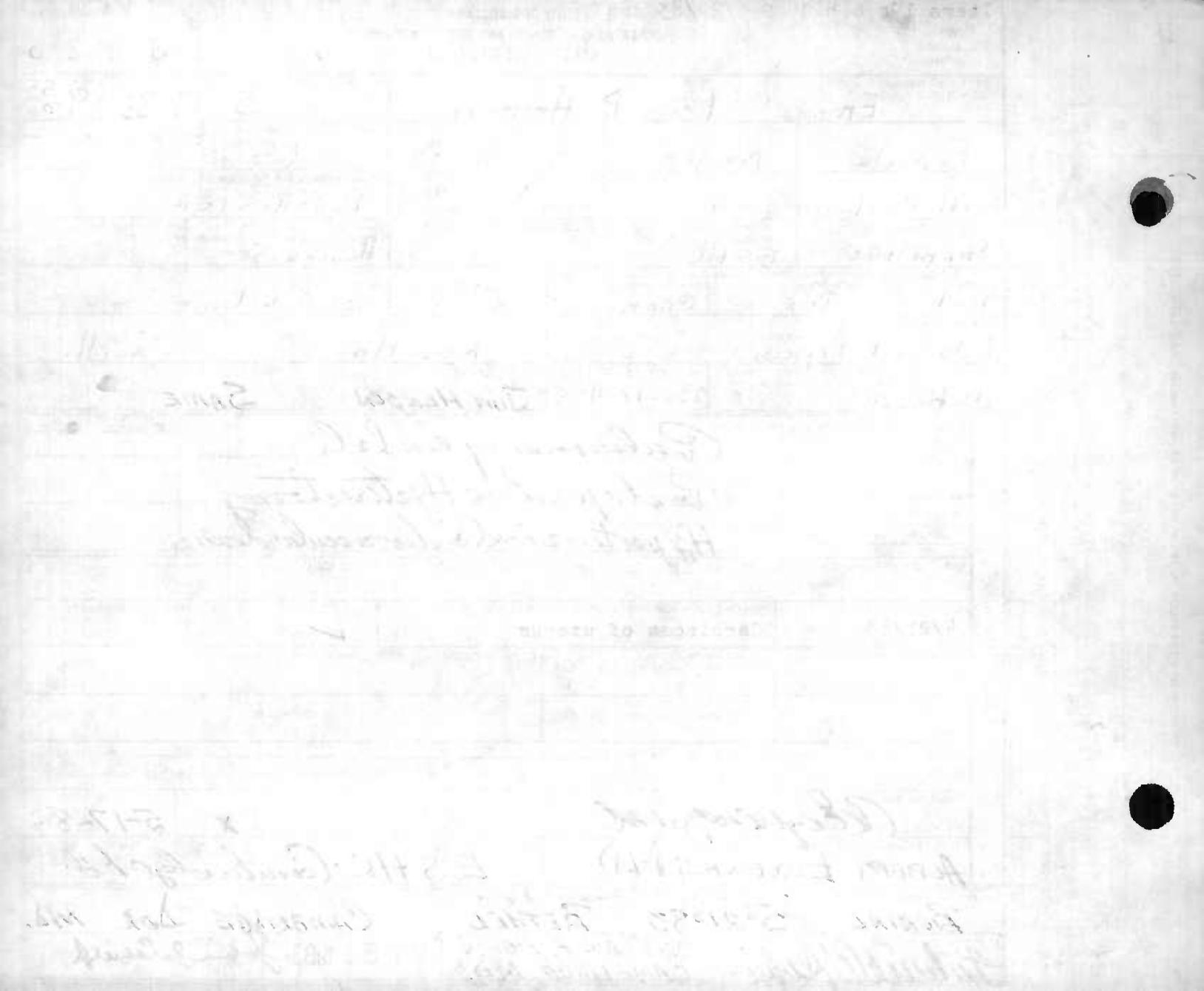
4 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of the death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items 19a & b G580 6/27/83 dad STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1 - STATE
REGISTRAR8 3
REG. NO.

1 3 4 2 6

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	26. DATE OF DEATH	MONTH	DAY	YEAR	28. HOUR		
Emma Love P. Henson						5	17	83	9 55			
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		Negro		MONTH	DAY	YEAR	65	YRS	MONTHS	DAYS	IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
North Carolina		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Dorchester					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
CAMBRIDGE		ESHC.					Housewife					
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Md.		Dor.		Camp.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		823 Park Lane - 21613			
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST				
Edward Pipkin					Novella			Smith				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Unknown		225-12-4518		Jim Henson			Same					
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
4029												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Post-operative Hysterectomy</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Extensive Cardiovascular disease</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
4/21/83		Carcinoma of uterus					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED			(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
Albert Esquenazi MD										5-17-83		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ST. CLAIR F. HOME			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE	
BURIAL		5-21-83		BETHEL			CAMBRIDGE		Dor.		MD.	
24 FUNERAL DIRECTOR NAME		ST. CLAIR F. HOME CAMBRIDGE, MD.					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John C. Blair							MAY 31 1983		John C. Blair			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5. RETAIN PAGE 5 WITHIN 24 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 4 2 7											
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/>			MONTH 5	DAY 17	YEAR 1983	2b. HOUR					
			Darlene			Renee			Jones														
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YR. MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH 5 DAY 17 YEAR 1983			9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester County			MD.					
Female		Black		Feb. 25, 62		21 yrs.																	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester County			10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Dor.			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 831 Park Lane			14. FATHER'S NAME FIRST Ernest MIDDLE Jones LAST Jones			15. MOTHER'S MAIDEN NAME FIRST Juanita MIDDLE Jones LAST Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			16d. ADDRESS			17. INFORMANT Juanita Jones			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of chest DUE TO, OR AS A CONSEQUENCE OF 9660 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			19c. DATE OF INJURY HOUR A.M. MONTH DAY YEAR 1:30 A.M. 5-17- 19 83			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subj. stabbed.											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) house			21c. LOCATION STREET 831 Park Lane, Cambridge, Dorchester, Md.			CITY OR TOWN COUNTY STATE			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. TITLE (SPECIFY) Dennis F. Smyth, M.D. Assistant			22c. MEDICAL EXAMINER			22d. DATE SIGNED 5-18-83														
23a. EXAMINER'S NAME (TYPE OR PRINT)			23b. ADDRESS 111 Penn St., Balto., Md. 21201			23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23d. DATE 5-21-83			23e. NAME OF CEMETERY OR CREMATORIAL St. Clair F. Home			23f. LOCATION CITY OR TOWN Salem			23g. COUNTY Dor.					
24. FUNERAL DIRECTOR NAME Tuberculosis			24b. ADDRESS Cambridge, Md.			24c. DATE REC'D. BY REGISTRAR MAY 31 1983			24d. REGISTRAR'S SIGNATURE John J. Conner			24e. STATE Md.											
25a. DHMH - 17 (VR A15 ME (5)) 20M 4/B2			25b. DATE REC'D. BY REGISTRAR MAY 31 1983			25c. REGISTRAR'S SIGNATURE John J. Conner			25d. STATE Md.														

comes

the right side of the

comes

comes

comes

comes

comes

comes

on

comes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please return carbon copies, Pages 1 and 2 should be retained for use at the burial/cremation permit. Then please return carbon copies, Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										RECD. NO. 83 13428				
1. DECEASED NAME (TYPE OR PRINT)		FIRST Joseph ASBURY			MIDDLE J.		LAST Jones		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
3. SEX		4. RACE			5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. IF UNDER 24 HRS			
Male		White			MONTH Mar. DAY 11, YEAR 1888		95 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.							Dorchester MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cambridge		Cambridge Nursing Home												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Md.		Dor.		Crocheron		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rural 21627						
14. FATHER'S NAME FIRST		MIDDLE		LAST		13f. MOTHER'S MAIDEN NAME								
Major				Jones		Ruth		Thomas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
NO		220-32-1042		A. Calvert Jones, Crocheron										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Cardio - Respiratory Arrest				
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD with Permanent Pacemaker				
										DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Spinae Brain Syndrome, VR1														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
E. Tannan														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
Burial		May 26, 1983		Dorchester Mem. Park, Cambridge, Dor., Md.										
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Thomas Funeral Home, Cambridge, Md., 21618					MAY 27 1983		John S. Cawie							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												83	13429							
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			Anna H. Katinsky			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
Katinsky			Anna H. Katinsky			518183						955 A.M.								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
F			Cau.			MONTH 9 DAY 24 YEAR 95			88			MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Ukraine			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Dorchester County											
8. OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Cambridge			Dorchester General			Homemaker														
13a. STATE 13b. COUNTY 13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
MD Dorchester Hurlock												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Wrights Avenue 21643					
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
John			Halanic			Helen			220-34-7634			John Katinsky Hurlock, MD								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			16c. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			16d. DEATH WAS CAUSED BY: DETERMINING CAUSE (b)			16e. DEATH WAS CAUSED BY: UNDERLYING CAUSE (c)								
No						congestive heart failure														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18b. DEATH WAS CAUSED BY: DETERMINING CAUSE (b)			18c. DEATH WAS CAUSED BY: UNDERLYING CAUSE (c)														
4280			degenerative heart disease																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b),																				
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (was) attended the deceased from saw the deceased alive on 5/18/83, and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Christopher S. Stoner			22c. DEGREE x 30			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Dorchester General Hospital Cambridge, MD			22f. DATE SIGNED 5/8/83					
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE					
Burial			5-11-83			Unity Washington			Hurlock, Dorch., MD											
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE John G. Conner														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 1 of 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3	1 3 4 3 0				
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST CHARLES MIDDLE CONRAD LAST LAUBACH			CHARLES C LAUBACH			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
M A R E			CAUC			2 26 1905			1983			5	4	83	2 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
M A R E			CAUC			MONTH DAY YEAR			78			MONTHS	MONTHS	YEARS	MONTHS	MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			X DORCHESTER			MD.		
Maryland			USA														
10. CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL			12a. MEDIUM OF OCCUPATION (TYPE OF INDUSTRY OR TRADE OF WORKING LIFE) STEEL IND.			12b. KIND OF BUSINESS OR INDUSTRY STEEL 1ND.								
13a. STATE MARYLAND			13b. COUNTY DORCHESTER			13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 3, Box 189			21613		
14. FATHER'S NAME FIRST CONRAD MIDDLE CHARLES LAST LAUBACH						15. MOTHER'S MAIDEN NAME EVA						16. ADDRESS Cambridge, Md. 21613			21613		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219-07-2123A			17. INFORMANT LAURA LAUBACH RT #3 Box 189						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Respiratory arrest			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (b) Cor Pulmonale									4 yrs		
						DUE TO, OR AS A CONSEQUENCE OF (c) Severe COPD									4 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a H63P																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I this Hospital) attended the deceased from <u>4/20</u> , 19 <u>83</u> , to <u>5/4</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we) did (did not) view the body after death.																	
22b. SIGNATURE H. L. Fiery			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 5/4/83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. L. Fiery						22e. ADDRESS 503 BYRN ST. CAMB. MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE May 7, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Pk.			23d. LOCATION CITY OR TOWN Airey, Cambridge, Dorchester, Md.			COUNTY			STATE		
24. FUNERAL DIRECTOR NAME Curran Funeral Home, 308 High St., Cambridge, Maryland 21613			ADDRESS			24a. DATE REC'D. BY REGISTRAR MAY 10 1983			24b. REGISTRAR'S SIGNATURE John G. Curran								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical certificate should be detached.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83 13431		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 5 18 1983							2b. HOUR 245 A.M.		
1c. DECEASED NAME (TYPE OR PRINT) Maggie Maggie			MIDDLE M.		LeCompte deCompte			6. AGE (IN YEARS LAST BIRTHDAY) 98		IF UNDER 1 YEAR MONTHS 0 YRS		
3. SEX F			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 11 1884			7. IF UNDER 24 HRS MONTHS 0 DAYS		8. IF UNDER 24 HRS HOURS 0 MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MD			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD.				
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General		12a. USUAL OCCUPATION Seamstress			12b. KIND OF BUSINESS OR INDUSTRY Clothing Manuf				
13a. STATE MD			13b. COUNTY Dorchester		13c. CITY OR TOWN Secretary			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 119 Main Street 21664		
14. FATHER'S NAME FIRST George MIDDLE Louis LAST Marvel			15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE Townsend LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-01-9145			17. INFORMANT Kythel Staton			20. ADDRESS 201 University Ave. Federalsburg, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/00 Respiratory Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-Respiratory Failure										10 days		
DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction Cerebro-Vascular Accident										10 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19, to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE Edmund J. MacLaughlin										22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J. MacLaughlin										22e. ADDRESS Byrn Street, Cambridge, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-20-83			23c. NAME OF CEMETERY OR CREMATORIAL East New Market			23d. LOCATION CITY OR TOWN E. New Market, Dor., MD		23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME N/A Zeller Funeral Home, E. New Market, MD										25a. DATE REC'D. BY REGISTRAR MAY 25 1983		
										25b. REGISTRAR'S SIGNATURE John J. Cawley		

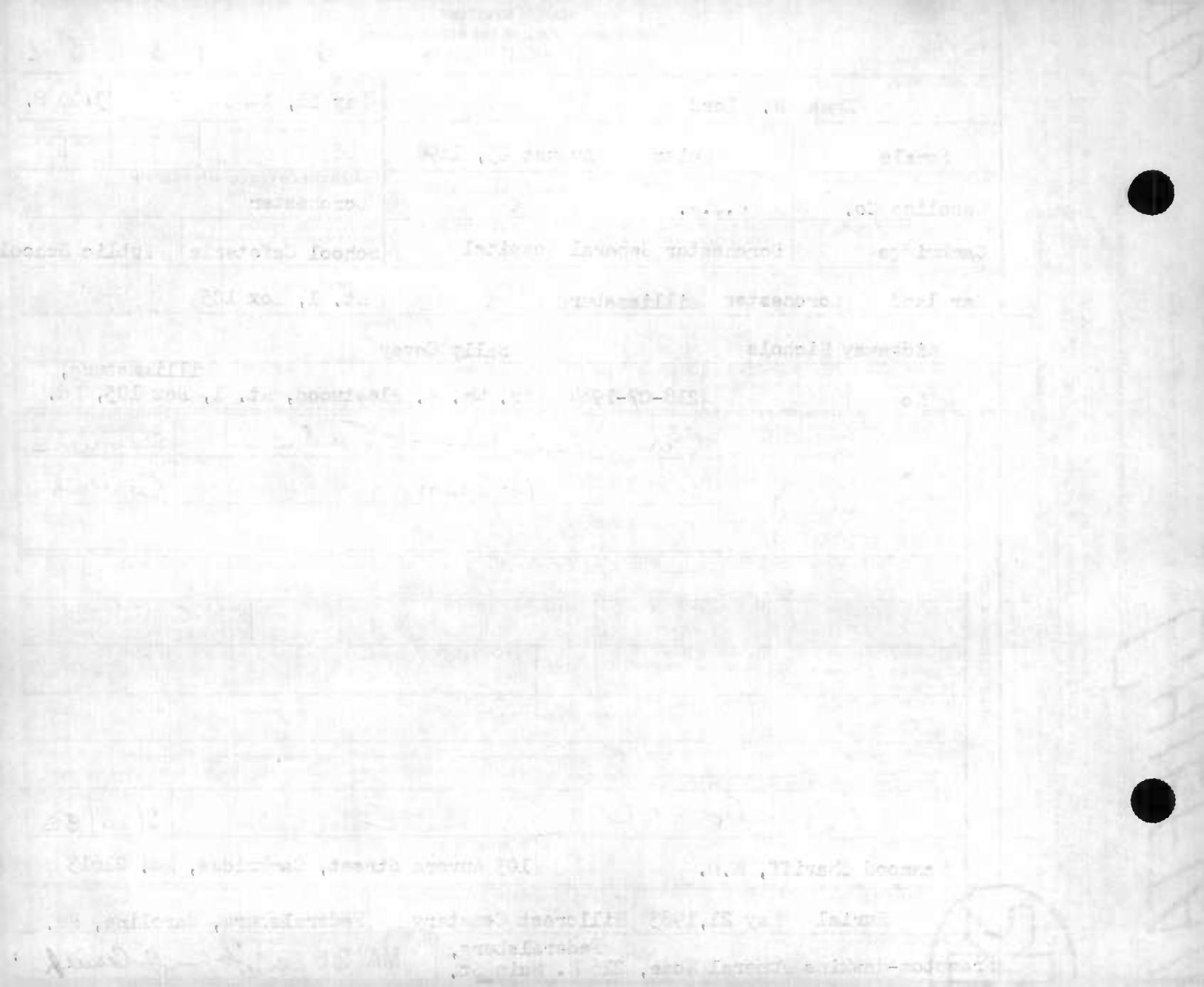
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be called.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 3 REG. NO. 1 3 4 3 2											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Emma N. Lord						May 18, 1983			3:00 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		August 25, 1894			88			YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Caroline Co.		U.S.A.					Dorchester				
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge		Dorchester General Hospital					School Cafeteria			Public School	
SPECIAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Dorchester		Williamsburg			Rt. 1, Box 105		21674		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Ridgeway Nichols		Sally Covey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			Williamburg, Rt. 1, Box 105, Md.	
No		218-07-1984		Mr. Wm. H. Fleetwood,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>One week.</i>											
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (b) <i>AS WD</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Soures.</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Colby DeMille</i>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>5/20/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mahmood Shariff, M.D.		22e. ADDRESS 105 Aurora Street, Cambridge, Md. 21613									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 21, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery			23d. LOCATION CITY OR TOWN Federalsburg, County Caroline, Md. State			
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.		ADDRESS Federalsburg,			25a. DATE REC'D. BY REGISTRAR MAY 25 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>			



CERTIFICATE OF DEATH

8 3 1 3 4 3 3

Phone no.

1. DECEASED-NAME (Type or print)	First MARY	Middle ELIZABETH	Last Moulton	2a. DATE OF DEATH Month 5 Day 25 Year 83	2b. HOUR 11:30 AM
-------------------------------------	---------------	---------------------	-----------------	--	----------------------

3. SEX Female	4. RACE White	5. DATE OF BIRTH 08-28-15	6. AGE (In years last birthday) 67	7. IF UNDER 1 YEAR MONTHS YRS.	8. IF UNDER 24 HRS. DAYS HOURS MIN
------------------	------------------	------------------------------	--	--------------------------------------	---

7. BIRTHPLACE (State or foreign country) Maryland	8. CITIZEN OF WHAT COUNTRY? USA	9. COUNTY OF DEATH Dorchester
---	------------------------------------	----------------------------------

10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hosptial Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dorchester	12b. KIND OF BUSINESS OR INDUSTRY Md.
--	--	--	---

13a. USUAL RESIDENCE (Where deceased admission) STATE Mo	13b. COUNTY Dor.	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 701 Race St.	13f. ZIP CODE 21613
--	---------------------	--------------------------------	---	--	------------------------

14. FATHER'S NAME Elmer	First Middle Willie	Last Fannie	15. MOTHER'S MAIDEN NAME Chart	Middle Horseman	Last Address
----------------------------	---------------------------	----------------	-----------------------------------	--------------------	-----------------

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 214-74-1034	17. INFORMANT Chart	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTI INFARCT DEMENIA</u>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40925
---	---	------------------------	---	--

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4019	DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPER TENSION</u>
DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
--	--	---

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
--	--	---

21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____
--	--	---

22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>5/25 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

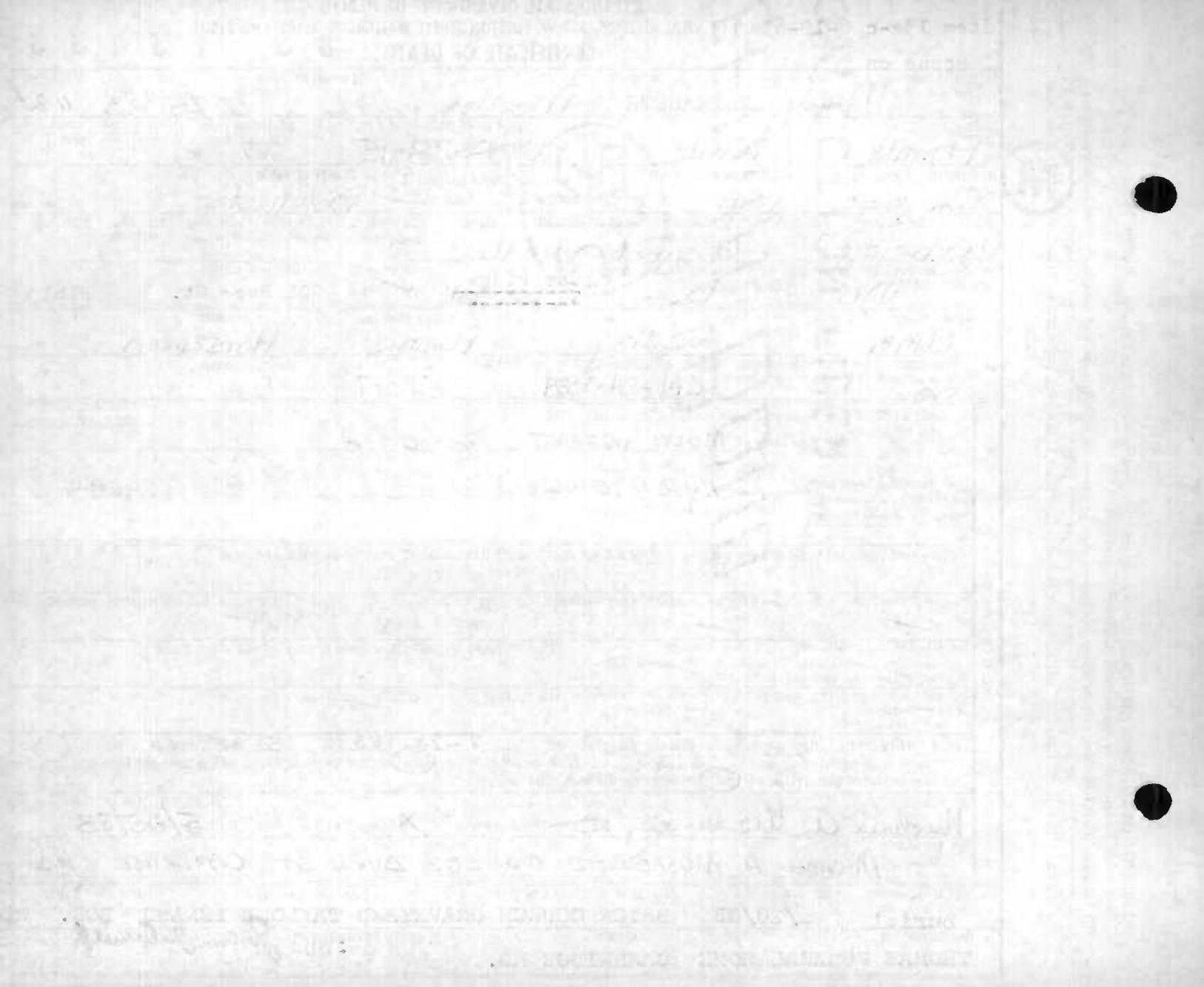
22b. SIGNATURE Michael A. Moskowicz <input checked="" type="checkbox"/>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/25/83
22d. PHYSICIAN'S NAME (Type) MICHAEL A. MOSKOWICZ MD	22e. ADDRESS 503 BYRN ST CAMBRIDGE MD.			

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 5/28/83	23c. NAME OF CEMETERY OR CREMATORIAL BRICK CHURCH GRAVEYARD TAYLORS ISLAND DOR. MD	23d. LOCATION (City or Town) (County) (State)
--	----------------------	---	---

24. FUNERAL DIRECTOR THOMAS FUNERAL HOME	ADDRESS CAMBRIDGE MD.	25a. REGD BY REGISTRAR JUN 3 1983	25b. REGISTRAR SIGNATURE John G. Smith
---	--------------------------	--------------------------------------	---

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event within 24 hours after death.



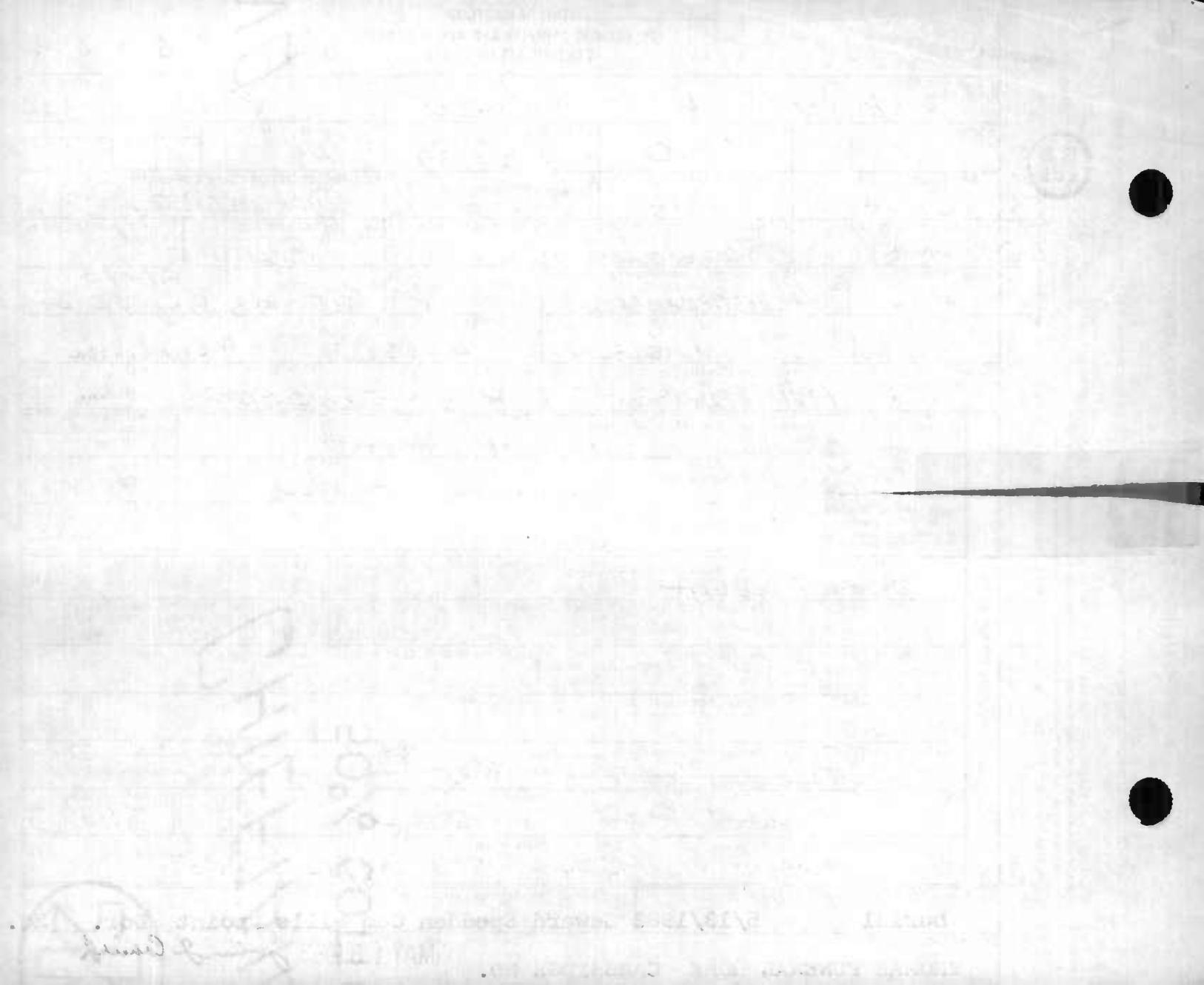
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial permit. Then please remit the burial permit with the State Dept. of Health and Mental Hygiene prior to burial arrangements.

IMPORTANT: If item 21 is marked or Item 18 above any injury, an attorney for the deceased must be present at the medical examination to have the medical examiner make the findings.

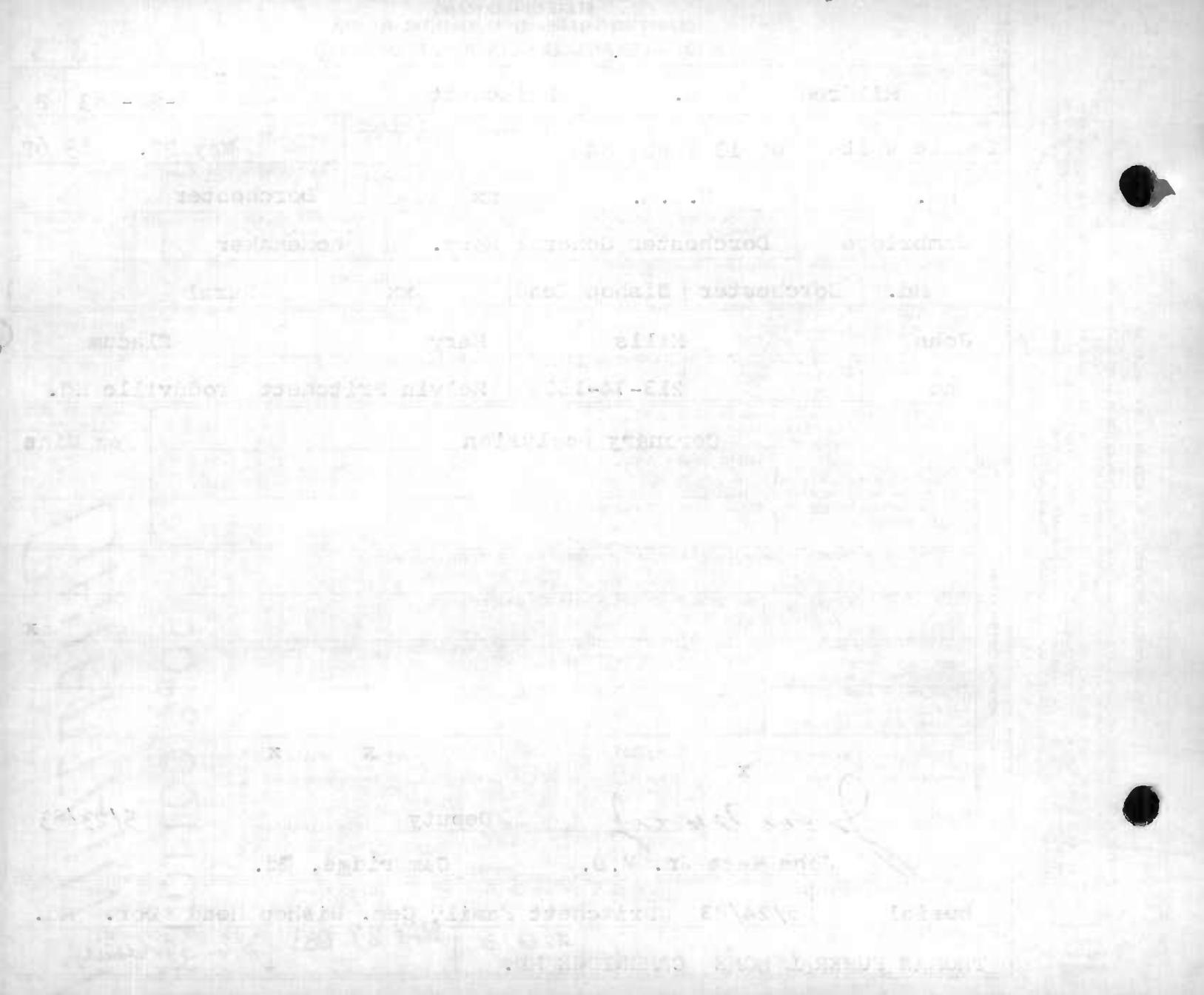
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	13434					
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
JOHN L NIELSEN				L	NIELSEN			5 10 83			5	10	83	15 3 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
M			CAUC			MONTH 2 DAY 24 YEAR 39			44			MONTHS	YEARS	MONTHS	HOURS	MIN.
7. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Penns			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			DORCHESTER							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
CAMB.			DORCHESTER GEN			13a. STATE MD.			13b. COUNTY DORCHESTER			13c. CITY OR TOWN CAMBRIDGE			21413	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD #3 Box 290-2							
HAROLD NIELSEN			EVELYN McNaughton													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
YES 1971-1972			21536-0348			BUCILLE NIELSEN			SAME			—				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) 4900										Respiratory Arrest						
DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLUS										7 days						
DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHITIS										7 days						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
QUADRUPLEGIA																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (1) (his hospital) attended the deceased from 5/13/83 to 5/10/83, the (1) (we) last saw the deceased alive on 5/9/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Hubert L. Fiery										DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/10/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert L. Fiery										22e. ADDRESS 503 BYRN STREET						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5/13/1983			23c. NAME OF CEMETERY OR CREMATORIAL Seward Spedden Cem. Hills Point Dor.			23d. LOCATION CITY OR TOWN COUNTY STATE Md.							
burial																
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR MAY 18 1983			25b. REGISTRAR'S SIGNATURE John J. Connelly							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 3 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 101 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 4 3 5
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED			MONTH	DAY	YEAR	2b. HOUR P.M.
Mildred			L.	Pritchett		<input checked="" type="checkbox"/>			5-22-1983			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR 6P.M.
female	white	08 13 1898	84 yrs.			<input checked="" type="checkbox"/>			May 22, 1983			
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.		U.S.A.						Dorchester				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge		Dorchester General Hosp.			homemaker							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY			
Md.	Dorchester	Bishop Head				Rural			71611			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
John			Mills	Mary				Slacum				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. INFORMANT			ADDRESS				
no		213-74-1534			Melvin Pritchett			Toddville Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF 4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					<input type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 5/23/83				
EXAMINER'S NAME (TYPE OR PRINT)		John Mace Jr. M.D.			ADDRESS Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE burial 5/24/83	23c. NAME OF CEMETERY OR CREMATORIAL Pritchett Family Cen. Bishop Head Dor. Md.			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD.	25. DATE REC'D. BY REGISTRAR MAY 27 1983			25b. REGISTRAR'S SIGNATURE 						
BP												
DHMH-17 (VR A15 ME(5)) 15M 7/77												



TO HOSPITAL OR ATTENDING PHYSICIAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP _____

DHMH-16 25M
(VRA 15, 4) 1/79

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

13436

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Rawlings				Robinson		5	17	83	9 A.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH 03 DAY 27 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Bishop Head		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21611			
14. FATHER'S NAME FIRST Linzie		MIDDLE LAST Robinson		15. MOTHER'S MAIDEN NAME FIRST Rhoni		MIDDLE LAST Bramble					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 428-58-0543		17. INFORMANT Wm. S. Robinson Bishop Head Md.		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4292</u> <u>Cardio-Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G. Cannan</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5/19/83		23c. NAME OF CEMETERY OR CREMATORIAL St. Thomas Churchyard		23d. LOCATION Bishop Head		CITY OR TOWN Dor.		COUNTY Md.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME		ADDRESS CAMBRIDGE MD 21613		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>John J. Cannan</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3	1 3 4 3 7	REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
John			L.			Sampson			Sampson			S. 6. 83						5 26 PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 7 DAYS					
MALE			Black			MONTH DAY YEAR			80			MONTHS DAYS			HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
East New Market			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Dorchester											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Cambridge			Dorchester General Hospital			Auto Mechanic			Transport Co.											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland			Dorchester			East New Mkt.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1, Box 64			21643					
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			FIRST			LAST					
John W. Sampson									Mary A. Thompson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			21643			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			214-12-5779			Wilbur Sampson			Rt. 2, Box 118, Hurlock, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.												Carcroma of the lung								
IMMEDIATE CAUSE (a) 1629																				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b)																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												Marasmus.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
~1A						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) (this hospital) attended the deceased from now (my) deceased alive on 5. 5. 83, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.			4. 19. 1983			4. 19. 1983			5. 6. 1983											
22b. SIGNATURE			WILKE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			WILKE			22e. ADDRESS			400 Maryland Ave			21643								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE					
Burial			May 11, 1983			Thompsonstown Cemetery			Thompsonstown			Dor., Maryland								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Frampton-Hawkins Funeral Home, 216 N. Main St.			Federalsburg			MAY 16 1983			John J. Conroy											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PLEASE SECURE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND FORWARD TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1M. 3 RETAIN COPIES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL Cremation, Removal, or Removal. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 3 4 3 8									
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED		MONTH DAY YEAR			2b. HOUR		
		Floyd A. Scye												5/18/83		19			M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR			2d. HOUR		
Male		Negro		July 5, 1928			54 yrs.			MONTHS		DAYS		HOURS		19			4:15 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8.			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Dorchester			MD.				
Columbia, Del.		U.S.A.																			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Dorchester General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Farmer			12b. KIND OF BUSINESS OR INDUSTRY		Farming					
Cambridge																					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			99999								
Delaware		Sussex		Delmar						Rt. 2											
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST								
Andrew C. Scye							Alberta Johnson														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Yes		WW Korean						Alberta J. Scye, Rt. 2, Delmar, Del. 19940						4100			?				
IMMEDIATE CAUSE (a)			Coronary occlusion										DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													(b)								
													DUE TO, OR AS A CONSEQUENCE OF								
													(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?								
													YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		Dr. John Mace, Jr.													TITLE (SPECIFY) M.D.		MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		604 Church St., Cambridge, Md. 21613													DATE SIGNED		5/20/83				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			CITY OR TOWN			COUNTY		STATE				
Burial			May 21, 1983			Mt. Nebo Cemetery			Columbia, Sussex, Delaware												
24. FUNERAL DIRECTOR NAME		Federalsburg, Md.													25a. DATE REC'D. BY REGISTRAR		REGISTRAR				
Frampton-Hawkins Funeral Home, 216 N. Main St.															MAY 25 1983		John J. Coughlin				
DHMH - 17 1VR A15 ME (5)) 15M 7/76																					

11.3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be sent with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at office.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 REC. NO. 1 3 4 3 9				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Leonard Carroll Stewart									5 29 83					1:00 P.M.		
3 SEX Male			4 RACE Caucasian		5. DATE OF BIRTH MONTH 02 DAY 02 YEAR 1945		6 AGE (IN YEARS LAST BIRTHDAY) 37 38 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester		10 CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Shore Hosp. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 210 Henry St.		213					
14 FATHER'S NAME First Edgar F. Middle Stewart			15 MOTHER'S MAIDEN NAME Grace													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO 217-44-1865		17 INFORMANT Jean Stewart		18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate		ADDRESS Item #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			19 DUE TO, OR AS A CONSEQUENCE OF (b)		20 DUE TO, OR AS A CONSEQUENCE OF (c)											
1729			Respiratory Arrest		Cancerous Metastases to Brain											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
None Known																
20a. MEDICAL CERTIFICATION			20b. DATE OF OPERATION		20c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20d. AUTOPSY? Unknown time of signature		20e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:00 P.M. May 29 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) as noted in #18											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (1) (this hospital) attended the deceased from October 29, 1980, to May 29, 1983, that (2) (we) last saw the deceased alive on May 21, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.																
22b. SIGNATURE Charles L. Ragan MD					22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 5/29/83							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Charles L. Ragan, MD			22f. ADDRESS Eastern Shore Hospital Center, Cambridge, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/1/83		23c. NAME OF CEMETERY OR CREMATORIUM GREEN LAWN CEM.		23d. LOCATION CITY OR TOWN CAMBRIDGE		COUNTY DOR.		STATE MD.					
24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME			ADDRESS CAMBRIDGE MD.		25a. DATE REC'D. BY REGISTRAR JUN 3 1983		25b. REGISTRAR'S SIGNATURE John L. Charles									

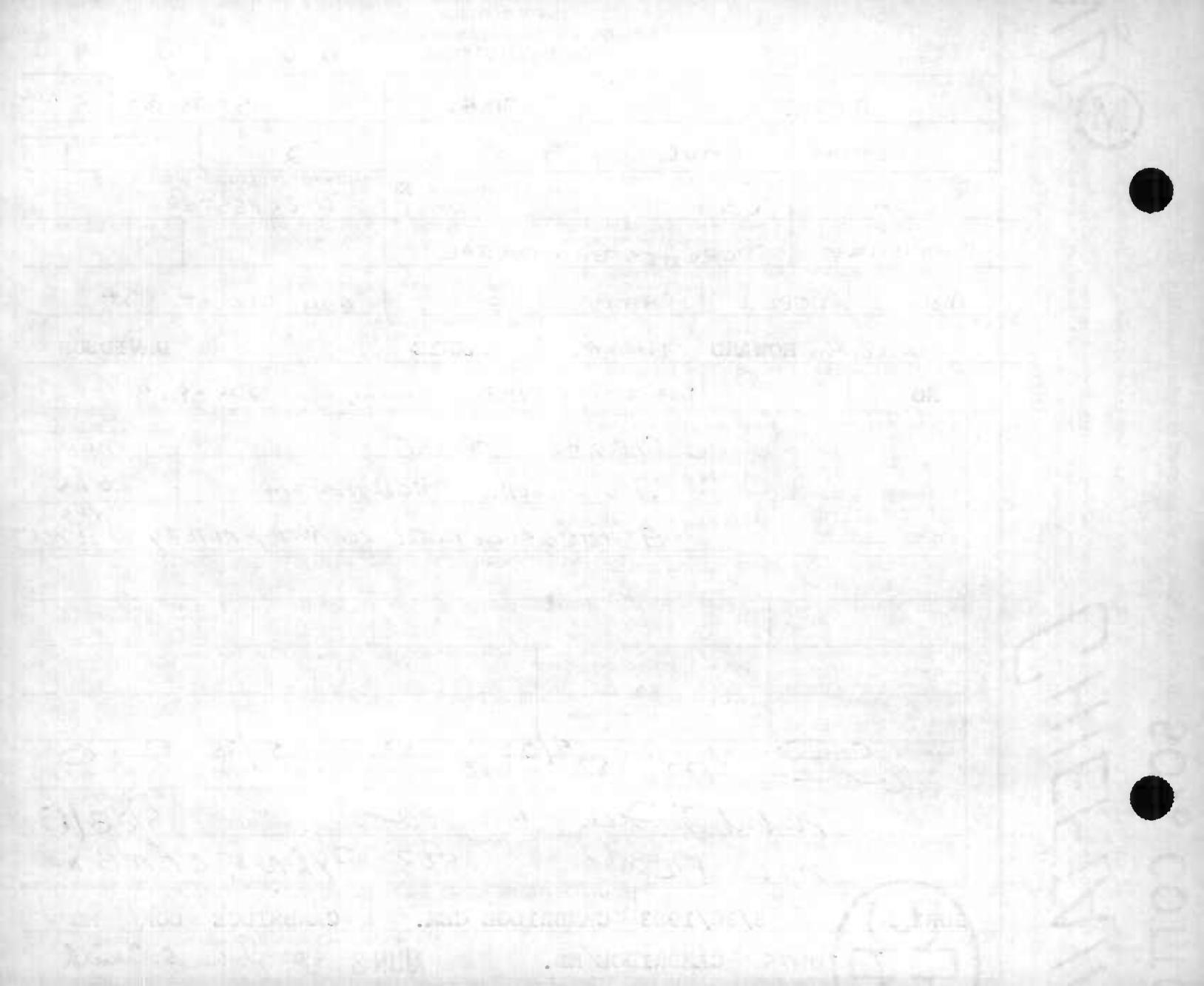
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner or coroner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
8 3 3 4 4 0 REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR				
MARIE			THOMAS			5 28 83			8 AM		M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		CAUC		MONTH 7 DAY 31 YEAR 90			92			MONTHS		DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
USA		USA					DORCHESTER								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CAMBRIDGE		DORCHESTER GENERAL													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md		DORCH		CAMP			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			604 LOCUST ST					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME											
		WILLIAM HOWARD THOMAS		NANNIE						DAVIDSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
NO		213-50-5794		MARY THOMAS			228-5669								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) CARDIAC ARREST 4140												min			
DUE TO, OR AS A CONSEQUENCE OF (b) VENTRICULAR TACHYCARDIA												6 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												YRS			
DUE TO, OR AS A CONSEQUENCE OF (c)ATHEROSCLEROTIC CORONARY ARTERY DISEASE															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/25/83 to 5/28/83, that (I) (we) last saw the deceased alive on 5/27/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.															
22b. SIGNATURE			DEGREE						22c. DATE SIGNED						
H. L. Ferry			MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						5/28/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			503 BYRN ST, CAMP MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			
BURIAL			5/30/1983			CAMBRIDGE CEM.			CAMBRIDGE			DOR			
24. FUNERAL DIRECTOR NAME												25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE			
THOMAS CAMBRIDGE MD.												JUN 3 1983 John J. Conner			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1 - STATE REGISTRAR			I DECEASED NAME (TYPE OR PRINT)			FIRST ROBERT MIDDLE MARTIN LAST WHEATLEY			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
3 SEX MALE			4 RACE CAU.			5 DATE OF BIRTH MONTH DAY YEAR SEPT. 15, 1917			6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.			7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER			10a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		
10 CITY OR TOWN OF DEATH CAMBRIDGE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION WHITE HALL RD. (home)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor			12b. KIND OF BUSINESS OR INDUSTRY Wire Cloth			13. STREET ADDRESS Cambridge, Md. 21613 RT. 2, BOX 75, White Hall,		
13a. STATE MARYLAND			13b. COUNTY DORCHESTER			13c. CITY OR TOWN CAMBRIDGE			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
14. FATHER'S NAME FIRST LUTHER MIDDLE WHEATLEY LAST			15. MOTHER'S MAIDEN NAME FIRST BERTHA MIDDLE LORD			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-12-5334			17. INFORMANT Wife Mrs. Pearl B. Wheatley, same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Prostatic Carcinoma</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1850</u> BETWEEN ONSET AND DEATH min														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic Adenocarcinoma unknown origin</u> <u>≈ 2 yrs</u> ?														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>4/25/83</u> to <u>5/4/83</u> , that <input checked="" type="checkbox"/> (I/we) last saw the deceased alive <u>4/25/83</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I/we) did not view the body after death.														
22b. SIGNATURE <u>Hubert G. Fiery</u>			22c. DEGREE <u>MD</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>5/6/82</u>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUBERT G. FIERY</u>			22g. ADDRESS <u>503 BYRN ST. CAMB. MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE May 7, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Pk. Cem. Airey, Cambridge, Dorchester, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME, 308 High St., Cambridge, Md.			25a. DATE REC'D. BY REGISTRAR Md. 21613 MAY 10 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Curran</u>								

